



MDS Care Plans

**A Person-Centered,
Interdisciplinary Approach
to Care**

Debbie Ohl, RN, M.Msc, PhD

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About the Author

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Debbie Ohl, RN, NHA, M.Msc., PhD, is a successful consultant and author of more than 30 years. She is owner and senior consultant at Ohl and Associates, a consulting practice dedicated to promoting quality outcomes and professional excellence in nursing facilities. Ohl is a registered nurse, nursing home administrator, skilled geriatric clinician, nursing home consultant, educator, and author; she is an expert in nursing facility regulatory guidelines and clinical practice, specifically assessment and care planning.

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Cheryl (Sherri) Jankowski, RN, graduated from Cuyahoga Community College, and has taken additional courses to become a Certified Legal Nurse Consultant. Sherri holds certifications in Case Management/Utilization Review, Diabetes Management, Cardiac Telemetry, Assistant Addiction Counseling, and Registered Nurse Assessment Coordinator (AANAC certified), and Train the Trainer. Sherri has written policy and procedure manuals for a variety of medical departments as well as contributed to survey prep and follow-up for nursing homes. She has written care plans, done MDS and care plan consulting, and now works as the Director of Healthcare Systems for Robintek, Inc.

Foreword

This book is intended to simplify care plans for real world use.

The government-designed Resident Assessment Instrument (RAI), consisting of the MDS (Minimum Data Set) and CAAs (Care Area Assessments), are critical tools used for care planning. The care plan is intended to reflect resident needs and wants, along with actions and timelines to address them. Care plans are intended to be used by caregivers to promote continuity of care and better outcomes. Unfortunately, most care plans are paper-compliant documents for surveyor use. They are not designed for routine use by caregivers.

The RAI not only drives care planning, but it also determines reimbursement rates, and generates quality measures used by regulators and multiple sources to assess facility status and outcomes.

The concept of a multi-functional, one size fits all document sounds good. In a computerized environment, its utility for care plans has had unintended consequences. Computerized care plans capture data from the MDS and generate a care plan. A typical plan lacks individuality and is often 20 to 40 plus pages long. Day to day use is impossible. The quality of the reviews are compromised by the volume of the care plans and the number of reviews scheduled.

The regulatory and reimbursement pressure for timely completion and submission of the MDS tends to fall to a few people. The primary goal of the process is to gather and enter the data for transmission. The care plans that are generated have little to no utility for everyday use.

When there is work to be done on the unit, it's hard to access a care plan that reads like a novel. Most of the staff has a good general knowledge of who the resident is and what needs to be done for them. The intention of the care plan is to deliver resident-specific information that facilitates a hands-on, best-practice approach to maintaining and improving functional status, medical conditions, and quality of life for the individual. General knowledge ensures the basic needs are tended to and functional tasks completed. On the other hand, specific knowledge creates the best outcomes for quality of care and quality of life.

Plans need to be clear, effective, and used. The formats in this manual are a stepping stone to transitioning care plans to workable tools.

The user assumes full responsibility for use of this manual. You are cautioned to stay abreast of regulatory changes and challenged to improve upon the ideas and content from your own experience.

The Evolution of Care Planning

Looking back in time can help us understand the significance of care planning. Federal involvement in nursing homes began with the passage of the Social Security Act in 1935. At the time, there were only public poor houses, which were dire at best; the majority of people in these poor houses were aged. The legislators did not want these places used to care for the elderly.

The Social Security Act established a public assistance program for the elderly, which proliferated the growth of voluntary and proprietary nursing homes. Consequently, in 1950, the Social Security Administration required states participating in the program to establish licensing programs, although the requirement did not specify what the standards or enforcement should be; consequently, little changed.

Bureaucracy moves slowly and is fraught with roadblocks for change. In 1956, a study of nursing homes called attention to problems with the quality of care. Most facilities were found to be substandard; staff members were poorly trained or untrained, and few services were provided. In 1965, the Medicare and Medicaid federally funded programs for nursing homes were significantly expanded; standards were uniformly put in place for nursing homes participating in the federal program. Few nursing homes were capable of meeting the health or safety standards or providing the level of service expected under the program.

In 1970 and 1971, nursing home problems came to the forefront with front-page news stories, such as a fire killing more than 30 residents in Ohio, food poisoning in a Maryland home killing 36 residents, and numerous horror stories about care atrocities. As a result, in 1972, Congress passed a comprehensive welfare reform bill that funded state survey and certification activities in an effort to establish and enforce uniform standards and conditions for operating nursing facilities. The federal law required a single set of standards to be developed. The emphasis was on the institutional framework rather than on the resident's care. Later in the 1970s and early 1980s, the Patient Care and Services Survey was created to rectify this problem. However, there was controversy over the legitimacy of this process, which had shifted the emphasis to the actual provision of care delivery using existing regulations. Very simply stated, having a policy was no longer enough, it had to be implemented, reviewed, and revised to get results; paper compliance in the form of policy and procedure was nearing its end.

The use of paper for care plans was the new gauge for ensuring resident care, although it would take another 20-plus years to achieve its intent. The move from paper to person in determining compliance has been a long road of transitions and lessons learned.

During the first phase of the care planning evolution, regulators demanded that each resident have a care plan that was multidisciplinary in nature. In other words, each discipline was required to have its own care plan. An unintended consequence of this approach was that each discipline became fearful of being cited if something was missing on its plans. Consequently, plans often contradicted one another and certainly missed the mark of being resident oriented (but the contradictions and omissions fueled survey deficiencies). This was particularly the case between nursing and dietary. The social services and activities departments generally looked at the nursing care plans and picked out some aspect to use on their plans. It took nearly a decade to move into the interdisciplinary care planning model. As with many changes in nursing homes, the transition to a unified care planning team began with the name change. We just started saying the care plan was interdisciplinary, but for the most part, things remained business as usual with care plans.

Intermixed during this period were other expectations (all designed to get us to pay attention and focus). Each diagnosis required a care plan, whether it was primary or secondary to the presenting problems or had no impact on current status. Surveyors told facilities that every medication was supposed to have a care plan (their interpretation). Once the industry got the hang of writing something on paper and calling it a care plan, regulators shifted the emphasis to phase two, which involved getting the writers to create measurable goals. It didn't matter that the goals did not measure anything meaningful in terms of functional status; they were measuring something (e.g., resident will be able to walk 4 ft. unassisted). The resident may have been able to walk 4 ft., but what did this actually mean for the resident? In retrospect, it was a way of teaching us the basics: What are you trying to accomplish and how will you know if you do?

Historically, care plans were rarely if ever used as a working tool for resident care. There were major growing pains, a lot of misinformation, and misguided understanding of what should and should not be care planned that resulted from rumors (the he-said/she-said phenomena). Confusion reigned, and care plans were a burden facilities dealt with. The plans were used as a tool for surveyors more than for resident care. Our care plans were driven by what we thought surveyors wanted to see. The process was mechanically driven; nonetheless, certain expectations were in place, and care delivery and its quality improved.

It took the Omnibus Budget Reconciliation Act of 1987 (OBRA) requirements to solidify the survey standards and process and to provide a framework for continuous improvement. The Minimum Data Set (MDS) 2.0 process was big help in the unification of the care team and including the resident as the primary player in the process and not just on paper. Formalizing the assessment process, expecting more in terms of care planning and care delivery, and outcome measurements, such as the quality measures, are essential tools to meet regulator, consumer, and professional expectations. In retrospect, job one was to improve the quality of care, which has absolutely occurred. Job two is improving the residents' quality of life by treating them as unique individuals with a lifetime of history. This transition started in 2000.

The MDS 3.0 has expanded the assessment process. The MDS and their sister the CAAs have created a more focused and in depth tool to structure resident focused, quality of life oriented care plans. Computer companies have responded with lengthy computerized plans that are pages and pages of data triggered from completed RAIs. While it may help surveys confirm information from the

assessment, these plans are not effectively utilized by day to day caregivers for resident care. These plans are simply too lengthy to be a functional tool. We are finding ourselves at the next crossroad: meeting regulatory care planning requirements while having a functional plan that captures the essence of the person for day to day use.

Why Care Plans Must Move Toward Functionality

In 2013, several Office of Inspector General studies and investigations found that SNFs had deficiencies in quality of care, did not develop appropriate care plans, and failed to provide adequate care to beneficiaries. In fiscal year 2012, Medicare paid \$32.2 billion for SNF services.

The reviewers determined the extent to which SNFs developed care plans that met Medicare requirements, provided services in accordance with care plans, and planned for beneficiaries' discharges as required. Reviewers also identified examples of poor quality care. The OIG findings revealed that:

- SNFs did not develop care plans that met requirements or did not provide services in accordance with care plans in 37% of stays.
- SNFs did not meet discharge planning requirements in 31% of stays.
- Medicare paid approximately \$5.1 billion for stays in which SNFs did not meet these quality-of-care requirements.
- Additionally, examples of poor quality care related to wound care, medication management, and therapy were also present.

To this end, the OIG recommendations and the CMS agreement with those recommendations was as follows:

1. Strengthen regulations on care planning and discharge planning.
2. Provide guidance to SNFs to improve care planning and discharge planning.
3. Increase surveyor efforts to identify SNFs that do not meet care planning and discharge planning requirements.
4. Link payments to meeting quality-of-care requirements.
5. Follow up on SNFs failing to meet care planning and discharge planning requirements.

IMPACT Act: Improving Medicare Post-Acute Care Transformation Act of 2014

The OIG findings and CMS's agreement with them have generated new demands for the long-term care community. The IMPACT Act of 2014 has been designed to address the Medicare beneficiary experience during long-term care stays and upon discharge to other care settings. Reigning in cost, standardizing post-acute quality care measures and improving the provision of care are the ultimate goals. The Impact Act will be progressively rolling out its provisions through 2022.

An October 2014 CMS Survey and Certification Memo revealed the expansion of the MDS and Staffing Focused Surveys to begin in FY 2015. The CMS memo highlights included:

- CMS will collaborate with states to identify the specific facilities to be surveyed.
- CMS is developing both the survey protocol and tool for the States to use.

- The surveyors will ask a series of questions regarding staffing and MDS related practices of the facility staff, leadership, and others as appropriate.
- MDS 3.0 inaccuracies and insufficient staffing found during survey will result in relevant citations, including those related to quality of care and quality of life.
- If care concerns are identified during on-site reviews, the concerns may be cited or referred to the State Agency as a complaint for further review.

The long-term care community must be proactive and begin evaluating and modifying assessment and care planning practices. The care plan must clearly reflect a holistic picture of the resident's quality of life and quality of care needs. The care plan also must become a functional tool used routinely to deliver care and assess outcomes in a clear and distinct manner. This is the next step in the evolution of care planning.

Appendix 1

Active Disease Diagnosis

CANCER

(1 of 3)

Resident name _____ Date _____

Problem/need	Related to	Risks/challenges
Reduce or eliminate adverse effects of cancer treatment problems that may occur during and after treatment.	<input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiation <input type="checkbox"/> Surgery <input type="checkbox"/> Immunotherapy <input type="checkbox"/> Other _____	<input type="checkbox"/> Nutritional compromise ___ Loss of appetite ___ Taste changes ___ Dry mouth ___ Nausea ___ Vomiting <input type="checkbox"/> Quality of life compromised

In My Own Voice: Specific wishes and preferences about this particular area

N/A None Already noted

CANCER

(2 of 3)

Goal(s)	Freq.	Interaction and approaches	Disc.	Target date
Resident nutritional compromise will be lessened and/or eliminated by maintaining hydration, stabilizing weight, and promoting the enjoyment of meals.		<ul style="list-style-type: none"> <input type="checkbox"/> Eat small meals and healthy snacks several times per day that contain plenty of calories and protein, including cheeses, milkshakes, puddings, ice cream, etc. <input type="checkbox"/> Add extra calories and protein to food (such as butter, skim milk powder, honey, or brown sugar). <input type="checkbox"/> Substitute poultry, fish, eggs, and cheese for red meat; add spices and sauces to foods. <input type="checkbox"/> Eat meat with something sweet, such as cranberry sauce, jelly, or applesauce. <input type="checkbox"/> Provide liquid supplements, such as soups, milk, juices, shakes, and smoothies, when eating solid food is a problem. <input type="checkbox"/> Clean teeth (including dentures) and rinse mouth after each meal and before bedtime. Avoid mouth rinses containing alcohol. <input type="checkbox"/> Use sugar-free lemon drops, gum, or mints if there is a metallic or bitter taste in the mouth. <input type="checkbox"/> Use plastic utensils if foods taste metallic. <input type="checkbox"/> Offer foods and drinks that are very sweet or tart to stimulate saliva. <input type="checkbox"/> Encourage resident to drink even if not thirsty; drink 8–12 cups of liquids per day. This includes water, juice, milk, or foods that contain a large amount of liquid, such as puddings, ice cream, ice pops, flavored ices, and gelatins. <input type="checkbox"/> Limit drinks that contain caffeine, such as sodas, coffee, and tea (both hot and cold). 		

CANCER**(3 of 3)**

Goal(s)	Freq.	Interaction and approaches	Disc.	Target date
Quality of life will be enhanced through supportive care.		<ul style="list-style-type: none"> <input type="checkbox"/> Eliminate or control pain at a level tolerable for the resident. Refer to the pain care plan. <input type="checkbox"/> Encourage and provide opportunities to share thoughts and feelings during individual contacts. <input type="checkbox"/> Provide opportunities to share via support groups <input type="checkbox"/> Promote participation and/or completion of activities of daily living as the resident feels able. <input type="checkbox"/> Provide and encourage leisure pursuits and distraction, including: <hr style="width: 100%; border: 0; border-top: 1px solid black; margin: 5px 0;"/> <hr style="width: 100%; border: 0; border-top: 1px solid black; margin: 5px 0;"/> <input type="checkbox"/> Medicate for nausea/vomiting as ordered. Monitor for efficacy. Report adverse effects to MD. 		

DIABETES

(1 of 2)

Resident name _____ Date _____

Problem/need	Related to	Risks/challenges
<input type="checkbox"/> Diet controlled <input type="checkbox"/> Oral agent(s) <input type="checkbox"/> Oral agent(s) with prn insulin coverage <input type="checkbox"/> Insulin dependent <input type="checkbox"/> Blood sugar stable <input type="checkbox"/> Blood sugar unstable	<input type="checkbox"/> Compliant with treatment ___ Diet ___ Medication <input type="checkbox"/> Noncompliant with treatment ___ Diet ___ Medication	<input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Hyperglycemia

In My Own Voice: Specific wishes and preferences about this particular area

N/A None Already noted

DIABETES**(2 of 2)**

Goal(s)	Freq.	Interaction and approaches	Disc.	Target date
<ul style="list-style-type: none"> <input type="checkbox"/> Maintain blood sugar levels between _____ and _____. <input type="checkbox"/> Prevent crises from inadequate control of blood sugar levels, hypoglycemia, hyperglycemia 		<ul style="list-style-type: none"> <input type="checkbox"/> Diet modifications as planned. See the nutrition plan. <input type="checkbox"/> Exercise type: _____ <input type="checkbox"/> _____ <input type="checkbox"/> Exercise frequency: _____ <input type="checkbox"/> _____ <input type="checkbox"/> Timely administration of diabetic medicine. <input type="checkbox"/> Monitor blood sugar; if outside of acceptable range, give sliding scale insulin and/or contact the physician as indicated. <i>hyper-/hypoglycemia</i> <input type="checkbox"/> Be alert to signs of low blood sugar: sweating, nervousness, faintness, confusion, fatigue, weakness, headaches, inappropriate behavior, visual problems, inability to concentrate, seizures, increasing stupor. <i>hypoglycemia</i> <input type="checkbox"/> Immediately check blood sugar. Give juice. If unable to drink, give instant glucagon. Reassess blood sugar in 10 minutes. <input type="checkbox"/> Be alert to signs of high blood sugar: flushed, dry skin, drowsiness, nausea/vomiting, abdominal pain, soft sunken eye balls, red lips, decreased blood pressure, acetone breath, and increased respirations. Contact physician immediately. <i>hyperglycemia</i> <input type="checkbox"/> Increase monitoring during periods of stress, such as any signs/symptoms of infection to prevent hypoor hyperglycemia and dehydration. <input type="checkbox"/> Encourage consumption of diet and snacks as recommended. If intake changes or the resident is noncompliant with intake, increase observation for diabetic reaction. 		

MDS Care Plans: A Person-Centered, Interdisciplinary Approach to Care

Debbie Ohl, RN, M.Msc, PhD

Looking to develop a more comprehensive plan of care while improving MDS 3.0 accuracy? ***MDS Care Plans: A Person-Centered, Interdisciplinary Approach to Care*** helps you navigate recent changes to the RAI and includes more than 100 customizable care plan templates. With many updated regulations already in effect, this resource covers the IMPACT Act, QAPI, person-centered care, and survey changes, as well as the changes resulting from the ICD-10 transition.

Each care plan provides a framework for guiding the review of trigger areas and clarifying a resident's functional status and related causes of impairments. It also provides a basis for additional assessment of potential issues, including related risk factors. These thorough assessments provide the interdisciplinary team additional information to help them develop a comprehensive plan of care. By modifying the care plans provided in this resource, you'll fit the individual needs of your residents while satisfying the requirements of the new assessment process.

This product will help facilities:

- » Save time developing person-centered care plans using more than 100 customizable templates
- » Evaluate and create valuable Care Area Assessments (CAA) and improve MDS 3.0 accuracy
- » Integrate the voice of the resident, family, and staff in the development of the care plan
- » Be confident they're making use of proven tools and expert guidance

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